Patient Intake Form

Name: _____ **Date:** _____

Insurance: _____

Date of Birth: _____ **Male** ☐ **Female** ☐

Address: _____ **Marital Status:**

City, State, Zip _____

S	M	W	D	SEP

PCP Name & Phone _____

Cell: _____ **Cell Carrier**_____ **Work #:** _____

E-mail address: _____

Occupation: _____ **Employer:** _____

How did you hear about our office? _____

Mark (c) for current check ☑ and indicate the age when you had any of the following

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis
- ☐ Vision problems

Urination
- ☐ Overnight more 2x
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful defecation
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow

☐ Reg. ☐ Irreg. ☐ Pain / cramps

Days of flow: ____Length of cycle:

Date - 1st day last period:

Are you pregnant? ☐ yes, ☐ no

If yes, how many months?

How many children do you have? ____

Birth control method:

Date of last PAP test:

☐ normal, ☐ abnormal

Date of last mammogram:

☐ normal, ☐ abnormal

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Patient Intake Form

Give a brief detailed description of the problem you are currently experiencing: _____

_____

_____

_____

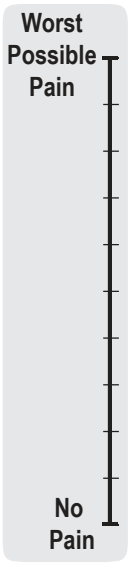
How long have you had this condition? _____ Is it getting worse? □ yes □ no _____

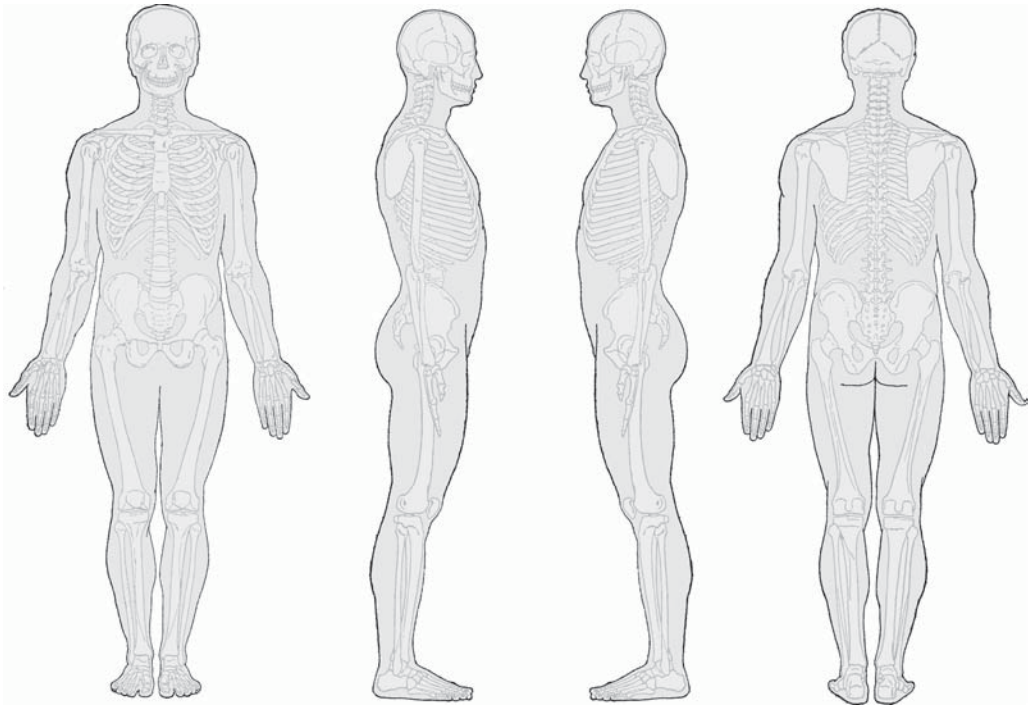
Does it bother you (check appropriate box): □ work □ sleep □ other: _____

What seemed to be the initial cause: _____

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:





Past health history

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 year?	□	□	_____
... had any mental disorders?	□	□	_____
... had any broken bones?	□	□	_____
... had any strains or sprains?	□	□	_____
... ever used orthotics?	□	□	_____
Do you take minerals, herbs or vitamins?	□	□	_____

How is most of your day spent? □ standing □ sitting □ other: _____

How old is your mattress?_____

When was your last physical exam? _____

Habits	none	light	mod.	heavy
Alcohol	□	□	□	□
Coffee	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Soft drinks	□	□	□	□
Salty foods	□	□	□	□
Water	□	□	□	□
Sugar	□	□	□	□

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

□ Alcoholism	□ Cancer	□ High blood pressure
□ Anemia	□ Diabetes	□ High cholesterol
□ Arteriosclerosis	□ Emphysema	□ Multiple sclerosis
□ Arthritis	□ Epilepsy	□ Osteoporosis
□ Asthma	□ Glaucoma	□ Stroke
□ Bleed easily	□ Heart disease	□ Thyroid disease

Please list all Medications and concerns

_____

_____

_____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name: _____ Date: _____

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

	Headache				Neck				Low Back		
No pain											**worst possible pain**
0	**1**	**(2)**	**3**	**4**	**(5)**	**6**	**7**	**(8)**	**9**	**10**	

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1 – What is your pain RIGHT NOW?

No pain										**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

2 – What is your TYPICAL or AVERAGE pain?

No pain										**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain										**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain										**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

OTHER COMMENTS:

_____

_____

_____

_____ _____

Patient's Signature Examiner's Signature

HIPAA Disclosure Form

Purpose of Consent

This Consent for the use and/or disclosure of personally identifiable health information is made pursuant to the requirements of 42 C.F.R. §164.506, which sets out the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by DeFalco Family Chiropractic (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Consent, I understand and acknowledge that I have the right to review the Privacy Notice prior to signing this Consent.

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing. I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (**leave blank if no restrictions**): _____
   _____
   _____

5. I understand and acknowledge that I may revoke this Consent at any time by sending a written revocation to the Practice at the address set forth in (3) above. However I also understand and acknowledge that if I revoke this Consent, my revocation will not be effective to the extent that the Practice has already acted action in reliance on this Consent.

   I understand the foregoing provisions, and I wish to sign this Consent authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

By signing this form I acknowledge that I have reviewed this consent and agree to the practice's use and disclosure of my protected health information for treatment, payment, and healthcare operations.

_____ _____
Patient or Guardian Signature Date

_____ _____
Witness Date

DeFalco
Family Chiropractic

FINANCIAL AGREEMENT

1. I understand that health insurances, worker's compensation, motor vehicle/personal injury and other third party payer policies are arrangements by and between insurance carriers and the subscriber. **Furthermore, I understand that it is my responsibility to be aware of the benefits available to me through my insurance carrier and that it is in my best interest to call my health insurance company and verify my individual benefits.** I understand that I am responsible for securing a **REFERRAL, PRE-AUTHORIZATION** and/or **CLAIM NUMBER** from my **HEALTH INSURANCE CARRIER, WORKER'S COMPENSATION CARRIER** and/or **MOTOR VEHICLE/PERSONAL INJURY THIRD PARTY PAYER**. If this information is not provided to **DeFalco Family Chiropractic (hereinafter DFC)** at the time of my **FIRST VISIT**, I agree that I am responsible to **pay out-of-pocket for the services rendered to me** until such time the information (referral, claim number, pre-authorization and prescription) is provided to **DFC.**
2. I authorize the release of any and all medically necessary information to process all claims related to services rendered at DFC.
3. I authorize payment of medical benefits directly to **DFC** for professional services rendered.
4. I understand that **payment** for all services rendered to me is ultimately my **individual** responsibility.
    - **Co-payments and payments toward deductibles/co-insurances** are due and payable at time of service.
    - Any and all unpaid balances for professional services are due within **30 days of discharge** from services at **DFC.** If payment is **NOT received within 30 days, all balances** are subject to an **18% finance charge annually.**
5. **DFC requires a 24 hour cancellation notice. There is a $25.00 service fee for NO-SHOWS or CANCELLATIONS without proper notice. This charge is NOT covered by your medical insurance and is billed directly to the client and will be collected at the time of the next scheduled appointment. Repeated missed appointments may warrant discontinuance of care.**

   _____(patient initials).
6. Your appointment may be cancelled and you may be charged for the cost of your treatment session, if you are more than 10 minutes late for your appointment.
7. There is a $35.00 returned check fee.
8. **If there are any changes to your Health Insurance Benefits or Carrier, it is your responsibility to notify and update DFC within 10 business days.**
9. **If your injury is related to a Motor Vehicle Accident, Personal Injury or a Worker's Compensation Injury, it is your responsibility to inform DFC.**
10. **It is your responsibility to inform DFC if you have secondary insurance.**

It is DeFalco Family Chiropractic responsibility to provide quality patient care, verify each patient's insurance benefits, to file insurance claims as a courtesy to the patient. A 60-day period will be extended for pending insurance payment, after which the patient may be held responsible for the entire balance.

By signing this form, I acknowledge that I have reviewed and agree to DFC's use and disclosure of my private healthcare information (HIPAA) for treatment, payment and health care operations.

I have read and agree with all the provisions within **DFC's financial agreement**. I further acknowledge that all the information given, whether oral or written by me to DeFalco Family Chiropractic is true.

_____ _____

PATIENT or GUARDIAN SIGNATURE **Date**

_____ _____

Signature of Authorized Clinic Representative **Date**

DeFalco
Family Chiropractic

Informed Consent to Chiropractic Treatment

The Nature of Chiropractic Treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular incident could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular incident, has been estimated at one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other Treatment Options: May include over-the-counter analgesics, prescription medications, injections, and surgery.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

No Warranty: I understand that my doctor at DeFalco Family Chiropractic, cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my doctor will share with me his opinion regarding potential results from chiropractic treatment for my condition and will discuss treatment option with me before I consent to treatment.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

_____	_____	_____
Printed Name	**Signature**	**Date**

WITNESS:

_____	_____	_____
Printed Name	**Signature**	**Date**

Consent to Treat Minor – For use when applicable

I hereby authorize DeFalco Family Chiropractic doctors of chiropractic, to administer chiropractic care, as deemed necessary, to my child.

_____	_____	_____
Name of Child	**Signature (Parent or Guardian)**	**Date**